STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE AND CONSUMER SERVICES AGENCY • ARNOLD SCHWARZENEGGER, GOVERNOR
Bureau of Naturopathic Medicine
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CONSUMER COMPLAINT FORM

Instructions for Filing Your Complaint

- ✓ Fill in the name and address of the naturopathic doctor or unlicensed person claiming to be or practicing as a naturopathic doctor.[1] Include the name, address, and license number (if known) of the person whom you are filing a complaint against as well as the name of the facility or practice group, if applicable. For unlicensed practice, include applicable e-mail or Internet addresses.
- ✓ Fill in your full name, address, and telephone numbers. Also, write this information in the first section of the "Authorization for Release of Patient Health Information" of the reverse side of the Complaint Detail Form. Please note, the "Authorization for Release of Patient Health Information" need only be filled out if your complaint is against a naturopathic doctor (ND).
- ✓ Write your complaint and include as many specific details as possible (who, what, where, why). Include the date(s) of treatment and specific examples of the problems with the care and treatment and use extra sheets of paper, if needed. Send us copies of any documents in support of your complaint which may include patient records, photographs, audiotapes, correspondence, billing statements, proof of payments, advertisements, web sites, etc.
- ✓ If the patient has seen **another naturopathic or medical doctor** for the **same problem**, include the name, address, and date(s) of treatment on the release section of the complaint form.
- ✓ Sign and date the complaint form at the bottom of the page and on the "Authorization for Release of Patient Health Information".

Authorization for Release of Patient Health Information

The "Authorization for Release of Patient Health Information" found below is a legal authorization for the Bureau of Naturopathic Medicine's staff to obtain information about the patient's care from the doctors and/or medical facilities involved in the medical care. **ANY EXTRA COMMENTS, NOTATIONS, ETC., MAKE THE FORM VOID AND WE WILL HAVE TO ASK YOU TO COMPLETE ANOTHER RELEASE FORM.** If you wish to provide us with additional information, please do so using a separate sheet of paper. If there are more than three naturopathic doctors, physicians, or medical facilities, you may copy the blank form in order to have enough spaces. When this form is completed and signed, it allows the Bureau of Naturopathic Medicine to order records from **ONLY** the doctors or facilities you have listed on the medical record release form.

Print or **type** the patient's name, date of birth, date of death, and medical record number if applicable in the first section. If we need to contact you to clarify your information, it will delay the review process. Fill in the names and addresses of all other health care providers where the patient was seen for the medical problems **in this specific complaint** (doctors and /or clinics or hospitals, etc.) in the second section. **RETURN PAGES 2, 3, AND 4 TO THE ADDRESS LISTED ABOVE.**

[1] Enforcement authority regarding licensure and unprofessional conduct is authorized by California Business and Professions Code Sections 3660 to 3663. Also see California Code of Regulations, Title 16, Sections 4242 to 4260.

I wish to complain about the individual named below. I understand that the Bureau of Naturopathic Medicine does not assist citizens seeking return of their money or other personal remedies. I am, however, submitting this information so that it may be determined whether disciplinary action against this practitioner's license should be considered.

PROFESSIONAL YOU WANT TO FILE A CLAIM AGAINST:

SUBJECT INFORMATION *(Naturopathic Doctor or Unlicensed Person Claiming to be an ND) Complete All Known Information.*		
Name: *(Last, First, MI)*		
Business or Employer Name:		
Address: *(Number & Street)*		
City:	**State:**	**Zip Code:**
Business Phone:		
E-mail Address:		
Internet Address:		
Additional Information:		

ABOUT YOU:

PERSON REGISTERING COMPLAINT *(May be Anonymous unless investigation requires an* **Authorization for Release of Patient Health Information***)*		
Name: *(Last, First, MI)*		
Address: *(Number & Street)*		
City:	**State:**	**Zip Code:**
Home Phone:	**Business Phone:**	
E-mail Address:		
Relationship to ND or Person Claiming to be ND:		

NOTE: The "**Authorization for Release of Patient Health Information"** form must be signed and dated **by either the patient or the individual legally authorized to make medical decisions for the patient.** If the patient is unable to sign the release, the form may be signed by: 1) the next of kin, if the patient is deceased (provide a copy of the Death Certificate); 2) the parent of a minor child; or 3) the person named by the patient is a signed Power of Attorney granting the person authority to make **medical decisions** for the patient (provide a copy of this document).

DETAILS OF COMPLAINT *(Who, What, Where, Why, How, When. Include Copy of Relevant Documents)*

Signature: _____ _____

Patient Date

Or

_____ _____

Legal Representative Date

Authorization for Release of Patient Health Information

This form is required **only** if your complaint is against a licensed naturopathic doctor.

Patient Name:_____

Medical Record No. _____ Date of Birth: _____
(If applicable)

Social Security No.: _____ Date of Death: _____
(Optional) (If applicable)

I, the undersigned , hereby authorize: (*Please list one Doctor, Physician, or Facility in each box)*

Doctor or Physician:
_____
(Last Name) (First Name) (M.I.)

Address: _____

Phone Number(s) _____Treatment Date(s) _____

Doctor or Physician:
_____
(Last Name) (First Name) (M.I.)

Address: _____

Phone Number(s): _____ Treatment Date(s) _____

Doctor or Physician:
_____
(Last Name) (First Name) (M.I.)

Address: _____

Phone Number(s): _____ Treatment Date(s) _____

To provide record in the course of my diagnosis and treatment, including medical, psychiatric, alcohol and drug abuse patient records (original and/or electronic/computer generated) to the **BUREAU OF NATUROPATHIC MEDICINE,** a healthcare oversight agency. This disclosure of records authorized herein is required for official use, including investigation and possible administrative proceedings regarding any violations of the laws of the State of California. This authorization shall remain valid until the Bureau of Naturopathic Medicine of the State of California completes its investigation and proceedings arising out of the investigation.

A copy of this authorization shall be as valid as the original. I understand that I have a right to receive a copy of this authorization if requested by me. I understand that I have the right to revoke this authorization by sending written notification to the Bureau of Naturopathic Medicine, 1625 North Market Blvd., Suite S-202, Sacramento, CA 95834. My written revocation will be effective upon receipt be the Bureau of Naturopathic Medicine of California but will not be effective to the extent that such persons have acted in reliance upon this Authorization. I understand that the recipient of my information is not a health plan or health care provider and the released information may no longer be protected by federal privacy regulations.

A copy of this authorization shall be as valid as the original. I understand that I have a right to receive a copy of this authorization if requested by me.

Signature: _____ _____
Patient Date

Or

_____ _____
Legal Representative Date